DOCUMENT RESUME

ED 105 309 CG 009 677

TITLE	Heroin. Report Series 33, No. 1.
INSTITUTION	National Inst. on Drug Abuse (DHEW/PHS), Rockville, Md. National Clearinghouse for Drug Abuse Information.
REPORT NO	DHEW-ADM-75-198
PUB DATE	Jan 75
NOTE	24p.; Published jointly by the Clearinghouse and Donald R. Wesson Associates, San Francisco, California
AVAILABLE FROM	National Clearinghouse for Drug Abuse Information, P.O. Box 1908, Rockville, Maryland 20850
EDRS PRICE	MF-$0.76 HC-$1.58 PLUS POSTAGE
DESCRIPTORS	*Drug Abuse; *Drug Education; Government Publications; *Information Dissemination; *Narcotics; *Social Problems
IDENTIFIERS	*Heroin

ABSTRACT

The National Clearinghouse for Drug Abuse Information recognized the need for clarifying some of the more complex issues in drug abuse by gathering the significant research findings on each subject and developing fact sheets on the problem. This brief fact sheet presents information about treatment modalities, the pharmacology and chemistry of heroin, and opinions and practices of recognized authorities in the field. The report also attempts to provide background into the complexities of heroin as a drug and as part of a historical, socioeconomic, legal and biomedical problem. Three pages of the brief are devoted to a comprehensive list of pertinent drug abuse legislation beginning in 1906. (Author/PC)

FEB 10 1975

report series

NATIONAL CLEARINGHOUSE FOR DRUG ABUSE INFORMATION

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

ED105309

SERIES 33, NO.1

JANUARY 1975

BEST COPY AVAILABLE

The National Clearinghouse for Drug Abuse Information recognizes the need for clarifying some of the more complex issues in drug abuse by gathering the significant research findings on each subject and developing fact sheets on the problem. These fact sheets, which are part of the Clearinghouse Report Series, present information about treatment modalities, the pharmacology and chemistry of various drugs of abuse, and opinions and practices of recognized authorities in the field. This publication was prepared by the Clearinghouse and Donald R. Wesson Associates, 527 Irving Street, San Francisco, California 94122, under Contract No. HSM 42-72-99.

HEROIN

Diacetylmorphine, more popularly known as heroin (derived from the German word "Heroisch" which means large or powerful), was first marketed in 1898 as a nonaddictive substitute for morphine. Although its arrival was welcomed by many individuals who believed it could become a "cure" for morphine addiction, by 1901 the fact that heroin itself was strongly addictive was widely recognized.

CG 009 677

Since that time heroin use has fluctuated in response to the historical climate of restriction or relaxation of legislative controls. According to the Federal Strategy for Drug Abuse and Drug Traffic Prevention, 1974, the most recent evidence indicates a general decrease in usage due to wider treatment opportunities, positive programs for veterans of the Vietnam War, and a strengthening of drug traffic control.

This report attempts to provide background into the complexities of heroin as a drug and as part of a historical, socioeconomic, legal and biomedical problem.

History

Early records reveal that opium and certain other narcotic drugs such as hemlock are known to have been used in medicine. The earliest known mention of the poppy (from which heroin is extracted) is in the Sumerian language of a non-Semitic people from the uplands of Central Asia. These people later settled in Mesopotamia about 5 or 6 thousand years before the birth of Christ. As the people of Mesopotamia spread their culture and influence throughout the Near and Far East, it is believed that the opium poppy was eventually brought to China by the 10th century, A.D., where it was used as a cure for dysentery.

By the middle of the 19th century, opium smoking and addiction came to the United States when large numbers of Chinese people immigrated to this country to work on the great canal and railroad projects of that time. Opium smoking, a social pastime in China, became part of American culture.

Also, by the end of the 19th century, patent medicines containing significant amounts of opiate drugs, such as Dr. Barton's Brown Mixture, "Dover's Powder," and "Glydo-Heroin" were easily obtainable by nonprescription over-the-counter sales. These factors contributed to the growth of a fairly large opiate-dependent population in the United States.

Despite this general usage, there was little concern on the part of the medical profession and no more than a few warnings and rumbles from the lay press. "Morphinism" was recognized as a vice but not as a threat to life or morals. Opium, morphine and heroin appeared in relatively pure forms and were cheap and easy to obtain. With the advent of the hypodermic needle in 1853, the problem of chronic opium intoxication developed.

The Civil War, with its wholesale carnage and poor medical facilities on the field of battle, precipitated the first large-scale morphine addiction problem in the United States. The use of morphine as a painkiller was so widespread that one of the effects of the war was the creation of a large population of ex-soldier morphine addicts. In fact, morphine addiction became known as soldier's disease or Army disease. Until the Civil War, distribution of opium and morphine, which were widely used as therapeutic agents, was substantially unregulated.

At the turn of the century, the medical profession, recognizing the dangers of dependence, began to exercise increasing restraints in the prescribing of opiates. In addition there were growing attempts to control opiates through legislation. The Pure Food and Drug Act of 1906 forced the labeling of patent medicines that contained opiates and other "dangerous" drugs.

The alarming use of drugs by American troops stationed in the Philippines caused concern about the problem in the United States. In 1903 the American Pharmacological Association reported the situation and a Committee on Acquirement of the Drug

Habit was formed to study the use of opiates in this country, the Philippine Islands, and the Far East.

Conditions found to prevail in the Philippines when the United States assumed control were serious enough to warrant a thorough investigation of the opium problem throughout the Far East. The Philippines Opium Commission was formed in 1903; its report led to the total prohibition of the importation of opium into the Philippines except for medicinal purposes.

In 1906 the Right Reverend Charles H. Brent, an Episcopal bishop who had been a member of the Commission, wrote to President Theodore Roosevelt directing his attention to the new movement against opium that was developing. He suggested that because of our interests in the Philippines and the stand taken by us, it was an opportune time for the United States to call for international action to halt the opium traffic.

After considerable diplomatic effort on the part of the United States, the International Opium Commission convened at Shanghai in 1909. The original issue was the illicit opium traffic and growing abuse of opiates that existed in the Far East. It was later discovered that the abuse of opium had spread to the United States, and that morphine addiction was rapidly increasing throughout the world.

Fourteen nations were invited and all but Turkey sent a representative. The United States dominated the meeting, not because it had the biggest problem but because it took the most intransigent position. America suggested "votes in favor of immediate opiate prohibition as the goal everywhere" and refused to deviate from that stance. Other countries could not concur with this uncompromising posture. The Shanghai Conference did not produce a treaty; however, several resolutions designed to control the traffic in opium were agreed upon.

The United States began preparations for another conference which took place on December 19, 1911 at The Hague, in Holland. It was there that Germany proposed the participants agree that no treaty would go into effect until ratified unanimously by the conferees. This plan was accepted by all participants. A treaty was drafted but not adopted, and all parties returned to their homelands. In July 1913 the second Opium Conference convened, at which ratification of the 1911 treaty was to take place. The United States signed the treaty on December 10, 1913 but unanimity among the parties to the conference was not achieved.

A third conference was then called to abrogate the requirement for unanimous ratification, but all parties to this third conference could not agree to such a repeal. Notwithstanding, the United States ignored the lack of accord and unilaterally declared the 1911 treaty to be in force.

The 1911 conference helped American reformers on the homefront. In 1914, Congress passed the Harrison Narcotic Act, which sought to control narcotics and

drug abuse mainly through the use of the Government's taxing power. There had been considerable Congressional opposition to passage of this Act since some legislators maintained that it was unconstitutional and usurped the rights of individual States to regulate drugs. By presenting the Act as a necessary factor in meeting the United States' treaty obligation, proponents of the legislation were able to quiet some of the opposition. Indeed, several writers have suggested that The Hague conference was convened to force passage of the Harrison Act. With the enactment of this law, the unauthorized sale, possession or purchase of narcotic drugs became a criminal offense. The use of narcotics for other than medical reasons was now considered an illegal act.

Prior to the regulation, only a small percentage of addicts were known to be involved in criminal activity to support their drug dependency. It soon became apparent, however, there had developed an increasing relationship between drug dependency and crime.

The Act also marked the beginning of a decisive turn in the medical treatment of opium addiction in the United States. During the next 5 to 7 years, the determination of proper treatment for addicts was taken from physicians and relegated to law enforcement agencies. The position of U.S. medicine is best summarized by an editorial discussing the Harrison Act, which appeared in 1915 in the Journal of the American Medical Association:

> But what about the old habitues, persons suffering from painful and incurable diseases, and others to whom opium in some form is absolutely necessary? Every physician knows of such cases. For them the physician so long as he complies with the law of his own State can prescribe whatever he sees fit. But it must be done openly and without attempt at evasion and the physician must be ready and able at any time to justify his acts. The whole purpose of the law is to restrict the use of opium (and cocaine) to legitimate channels.

The Harrison Act itself stated:

> Nothing contained in this section (prohibiting distribution of opium, opiates and cocaine) shall apply
>
> a) to the dispensing and distribution of any of the aforesaid drugs to a patient by a physician, dentist, or veterinary surgeon registered under this Act in the course of his professional practice ....

However, the Treasury Department, which enforced the Act, maintained a different perspective. Treasury Decision 2200, announced May 11, 1915, indicated that "prescriptions for an addict's narcotics must show decreasing doses over time; were

this not the case the physician would be presumed to be violating the law." Once this precedent was established, the Treasury Department's orders became more restrictive until ultimately a physician's prescribing or providing any narcotic whatsoever to an unhospitalized addict was considered a prosecutable offense.

Before this attitude became firmly entrenched in the practice of American medicine and law, there were several court battles over various issues. One of the earliest was a District Court decision, U.S. vs Friedman, which determined that the law placed no limit on the amount of narcotics a physician could prescribe. Shortly after this, in 1919, the Harrison Act was finally declared constitutional by a narrow margin of five to four in the Supreme Court. On the same day the United States Attorney went beyond the case at hand (Webb and Goldbaum vs U.S.) and asked the Court:

> If a practicing and registered physician issued an order for morphine to an habitual user thereof, the order not being issued by him in the course of professional treatment in the attempted cure of the habit, but being issued for the purpose of providing the user with morphine sufficient to keep him comfortable by maintaining his customary use, is such an order a physician's prescription under (the meaning of the law)?

The Court voted, again five to four, that such a prescription was not a "proper" prescription. This decision was widely interpreted to indicate that any treatment of addiction with narcotics other than graduated withdrawal was illegal. Subsequent Treasury Department orders continued to withdraw and limit the American physician's prerogatives of treatment for addicts, many of whom had never been aware that their favorite patent medicines contained addictive drugs.

In response to the obvious need for some type of supervised care for the suddenly deprived addict population, the Annual Report of the Commissioner of Internal Revenue for the fiscal year 1918-1919 stated that "Emergency Clinics" should be set up to provide such care. By the time this report appeared in print, however, the Journal of the American Medical Association was already reporting that the Treasury Department had declared any prescription for an addict beyond his immediate need was forbidden and that "The Bureau does not approve of so-called reductive ambulatory treatment."

Narcotic dispensing clinics were first opened in Louisiana and California and later in a number of other States. More than 40 such establishments were in operation from time to time. Their objective was to withdraw the addicts by gradually decreasing the doses of narcotics. It was felt that the availability of free morphine would deter the addict from returning to illicit sources for the drug, control his addiction, and eliminate his antisocial behavior. Instead, addicts living in suburban and rural areas flocked to the cities to obtain free drugs. Petty crime increased as well as known addiction. These clinics operated for varying lengths of time and all were eventually closed in 1920 by order of the Commissioner of Internal Revenue.

Given the large number of people who were dependent on opiate drugs and the unavailability of medical treatment for these individuals, an illegal heroin market developed, causing addicts to turn to such channels to continue their opiate drug use. As controls became stricter the price of drugs rose, forcing addicts to engage in criminal activities to pay for their habits. As a consequence most narcotic users and their sources gradually became confined to urban ghettos and grew invisible to the majority of Americans.

By the 1960's heroin use became visible again to the general community when the phenomenon spread from the urban ghetto to the middle-class suburbs. The problem reached epidemic proportions and Federal measures were undertaken to educate the public, liberalize treatment opportunities and strengthen drug traffic control.

Pertinent legislation was passed in the form of the Drug Abuse Prevention and Control Act of 1970, PL-91-513, which superseded previous drug control laws and provided for the coordination of the prevention, treatment and research activities in the Federal Government. In addition, the Drug Abuse Education Act of 1970, PL-91-527, provided financial support for drug education programs in the schools.

In 1972, Congress passed legislation to strengthen the treatment and rehabilitation activities of the Federal Government by establishing the Special Action Office for Drug Abuse Prevention (SAODAP) to control and consolidate the effort from the White House. The legislation, which calls for the phasing out of SAODAP by June 1975, places the responsibility for continuing Federal drug programs in the National Institute on Drug Abuse (NIDA), Department of Health, Education, and Welfare.

Chemistry and Pharmacology

Opium is obtained from a milky substance contained in the unripe seeds of the poppy plant, papaver somniferum. This juice, when dried, forms powdered opium. Over 25 basic organic substances are found in opium, morphine being present in the greatest quantity.

Heroin is a highly effective narcotic analgesic, similar in pharmacological action to morphine, although its milligram potency as a painkiller is three to four times greater than that of morphine. Heroin produces an analgesic effect by a two-fold action on the central nervous system; the pain threshold is elevated and psychological response to pain is altered. Pain may still be recognized as being present, but the individual reacts less emotionally to it. In the body, heroin is rapidly metabolized by the liver and other body organs and tissues to monoacetylmorphine (MAM) which is further decomposed to morphine. Most evidence now available suggests that morphine is responsible for the pharmacological actions of heroin.

Heroin is excreted in the urine as morphine and also appears as morphine in breast milk, perspiration and saliva. Because of its low molecular weight, heroin crosses

the placental barrier and can produce physical dependence in the fetus of a pregnant addict.

During pregnancy the unborn child develops a dependency if the mother continues her narcotic addiction. At birth, the newborn infant is suddenly shut off from its supply of narcotics which it had been receiving from the mother's bloodstream, and within hours will suffer withdrawal symptoms. Although the newly born infant is often thought of as not difficult to cure, because it has no psychological dependence, failure to make an early diagnosis and begin treatment can endanger the life of the infant.

Patterns of Use

Heroin is smuggled into the United States through well-organized and long established criminal channels. One kilogram (2.2 pounds) of 80 percent pure heroin may be purchased by an "importer" for $5,000 to $7,000. Once in the United States, the heroin may pass through as many as seven different "cuts," or dealer dilutions, yielding an eventual profit of $250,000 or more. Milk sugar, quinine, cornstarch, or almost any white, powdery substance is used to dilute the heroin. The resulting "heroin" (fully deserving of the name "junk") may contain as little as one to two percent heroin. This material is sold in glassine packets containing approximately 250 milligrams (mg.) or in larger rubber "balloons" containing 350 to 400 mg. Each "bag" or "balloon" costs about $10 to $25.

Heroin is usually injected into the body. The addict generally prepares each injection as needed. Most addicts maintain their own equipment. Equipment that is shared might become unsterile and contribute in large part to infections (abscesses, hepatitis, septicemia, endocarditis, etc.) commonly observed in addicts. Were sterile equipment used in controlled situations, many of the medical complications of heroin addiction would not occur.

Heroin can also be "snorted." A portion of the dry powder is placed on a piece of paper beneath the nose and the powder drawn into the nostrils with a sharp, quick sniff. Heroin is readily absorbed through the nasal membranes. Some beginners experiment by "skin-popping" -- the injection of heroin under the surface of the skin.

Heroin is commonly smoked by users in the Far East. A mild form of dependence is produced by smoking relatively pure heroin mixed with tobacco in a "cigarette." The high temperature of the burning cigarette, however, destroys about 80 percent of the active effect of the heroin.

Physiological Effects

Of all the opiates, diacetylmorphine (heroin) has the greatest addiction potential. It produces both tolerance and physical dependence. Tolerance is a diminution in the drug effect which occurs with repeated administration. With physical dependence, body responses and processes become modified so that continued administration of the drug is required to prevent the onset of withdrawal symptoms.

Although heroin is rapidly converted to morphine in the body, an experienced user can differentiate heroin from morphine given intravenously because the pleasurable, whole body, warm, orgasmic "rush" occurs more rapidly and is more intense with heroin than with morphine. With subcutaneous injection ("skin popping") or intramuscular injection, an addict is unable to distinguish heroin from morphine.

Like morphine, heroin constricts the pupils of the eyes. It depresses both the rate and depth of respiration. With overdose, an individual may appear cyanotic (showing a bluish tinge of the skin due to insufficient oxygen in the blood) and may suffer cardiac arrest also due to decreased oxygen in the blood. Although the amount of carbon dioxide in the blood is increased, the response of the brain's respiratory center to carbon dioxide stimulation is greatly reduced. Often the respiratory rate is depressed to three or four breaths per minute. The greatest chance of accidental overdosage and death occurs in the heroin susceptible or "non-tolerant" individual (e.g., a beginner or someone who has been 'off" the drug for a while) or in the individual who concurrently injects or ingests a combination of respiratory depressant drugs, such as alcohol and/or barbiturates.

Other significant causes of death are due to complications caused by unsterilized needles and other equipment used for intravenous administration of the drug, allergic or hypersensitive reactions to adulterants added to "cut" the heroin dose, and direct toxic effects of the drug itself.

Heroin addiction frequently causes depression of sexual libido in both male and female users. Females frequently have decreased menstrual flow and, with daily heroin use, some cease to have menstrual periods altogether.

Histamine, an organic compound containing nitrogen which is a powerful dilator of the capillaries and a stimulator of gastric secretion, is released following heroin injection. Itching frequently occurs. The uncontrollable shaking of the body and collapse, i.e., "cotton fever," following a heroin injection, may be caused by an allergic phenomenon or a septicemia resulting from a dirty needle or "outfit." Constipation usually occurs because of the addict's poor eating practices and due to the depressive reaction of heroin on all of the vital organs of the body.

Nausea and vomiting are not uncommon and are more likely to develop if the user is up and moving around. Tolerance to these effects appears rapidly: once the addict's habit is firmly established, nausea and vomiting rarely occur.

With a large overdose of heroin, shock resulting from a general cardiovascular collapse may take place. In the tolerant individual there may be a slight drop in blood pressure following injection. Vasodilation of the skin occurs and sweating is stimulated.

Psychological Effects

To the heroin dependent individual, the classic effects of narcotics have different meanings and connotations than they do in medical practice. For individuals experiencing fatigue, tension, or anxiety, the euphoric effects of the drug afford considerable relief, allowing the individual to feel "larger than life." Although opium and the morphine alkaloids are not generally used therapeutically for mood alteration, due to their physical dependence liability, they are effective tranquilizers. Anxiety and feelings of inferiority disappear. Since the user becomes emotionally detached from reality, everything looks rosy until the pleasurable drug effects wear off and he needs another dose to pharmacologically restore his confidence. The property of producing euphoria (i.e., bodily comfort, well-being, and absence of pain or distress) and that of relieving anxiety or tension principally accounts for the danger of psychological dependence on heroin.

Treatment

Treatment: Overdose

Treatment of acute overdose (O.D.) entails assuring an open airway, providing artificial respiration and administering one of the narcotic antagonists (naloxone hydrochloride, nalorphine hydrochloride or levallorphan tartrate). Both nalorphine (Nalline) and levallorphan (Lorfan) can contribute to respiratory depression if more than two therapeutic doses are given within 30 minutes. Naloxone (Narcan) does not produce depression of respiration and is the current narcotic antagonist of choice in treatment of narcotic overdose. If the symptoms are due to narcotics overdose alone, antagonist treatment will result in prompt reversal of symptoms. Overdoses of methadone will also respond to narcotic antagonists but the pharmacological action of narcotic antagonists is relatively shorter-acting than that of methadone, and additional doses may be needed every few hours.

Treatment: Heroin Dependence

When the physically dependent heroin (or morphine, codeine or methadone) user abruptly ceases his use, he begins to experience "withdrawal." The gastrointestinal tract becomes overactive, exhibiting signs and symptoms of nausea, vomiting, diarrhea and abdominal cramps. The pupils are widely dilated, the nasal mucosa produces an abundant discharge of watery fluid and saliva, and sweat production increases greatly. Insomnia is universal, as are generalized

aches, nervousness and pains (predominantly low back pain and bone pain). The addict also describes a continuing "drug craving."

Heroin withdrawal symptoms reach their peak of severity at 24 to 36 hours following termination of drug use, then begin to decline and mainly cease by 72 hours. Dramatic signs are over in 7 to 10 days. Symptoms like insomnia, "nervousness" and irritability may continue for anywhere from several months to a year. Many ex-addicts also describe a periodic craving for narcotics which may persist for 10 to 20 years. It is this continued craving for narcotics - the abstinence syndrome - that makes addiction so difficult to treat over a long period of time.

Non-narcotic treatment of acute withdrawal can be accomplished by systematically treating each symptom with non-narcotic medications (e.g., belladonna alkaloids for nasal discharge, nausea, vomiting, diarrhea, and stomach cramps; mild hypnotics and sedative-hypnotics for nervousness and insomnia; and non-narcotic analgesics for bone and muscle aches). During the withdrawal period, access to psychological counseling and peer support are usually helpful.

Methadone, a synthetic narcotic developed in Germany during World War II, is the narcotic withdrawal agent most commonly employed in the United States. Its primary advantage is its oral effectiveness and long (12 to 24 hours) duration of action. Methadone alleviates narcotic withdrawal symptoms. Administered orally and given in decreasing doses over a 7 to 10 day period, methadone allows a relatively symptom free withdrawal detoxification or maintenance. The patient thus withdrawn can then be channeled into aftercare facilities for continuing treatment and rehabilitation. Methadone in sufficient dose also blocks euphoric effects.

Research on narcotic withdrawal utilizing a substance similar to methadone, alpha-acetylmethadol, is now underway. Alpha-acetylmethadol is effective for a 2 to 3 day period in contrast to the 24-hour duration of methadone.

The type of non-drug approach that has become popular is the therapeutic community. The classic example of a therapeutic community is Synanon, which was founded in 1958 by Chuck Dederich. Oriented around "games" (or encounter groups), Synanon provides a life style in which individuals become part of a close and firm community which, in turn, supplies the necessities of life. Many therapeutic communities patterned after Synanon, including Daytop in New York and Reality House West and Walden House in San Francisco, have grown up around the country. All of these programs have in common "cold turkey" or drug-free withdrawal aided by the moral support and understanding of ex-addicts who have been through similar experiences, and the total abstinence from all drugs, including alcohol.

Another kind of treatment provided by programs employs narcotic antagonists. The theory behind this approach is that once the addict is "clean" he can be placed on an antagonist to block the effects of heroin. Narcotic antagonists have been utilized

for years by the medical profession to treat respiratory depression caused by narcotics. Of these antagonists, the two most widely known are nalorphine hydrochloride (Nalline) and levallorphan tartrate (Lorfan). These drugs are relatively short-acting, with a duration of from 20 to 40 minutes.

Two longer acting drugs, cyclazocine and naloxone hydrochloride (Narcan), recently have been used in treatment programs. Most treatment experience deals with cyclazocine and suggests that this drug has a certain small success rate. Many patients, however, find abrupt withdrawal or abstinence effects too unpleasant to continue taking the drug for prolonged periods of time. Naloxone is free of subjective effects but its use has been limited by its relatively short duration of action, expense, and variable absorption when taken orally.

Research is now underway for longer acting antagonists, which block the effects of heroin and are free from all other objectionable side effects. In addition, research is seeking suitable implants which could be inserted subcutaneously and release a narcotic antagonist into the body in timed doses over a period of a month or longer.

One premise on which virtually all addiction treatment programs agree is that merely treating withdrawal is just a beginning and must be combined with long-term therapy. It is essential to involve the addict in a program that will alter his self-destructive lifestyle and environment. To achieve this goal, programs have been developed which range from those that offer psychological counseling with vocational counseling, training, and social rehabilitation, to programs that attempt to involve the addict in radical social changes. Most programs employ ex-addict counselors in varying degrees and capacities. This role model is generally felt to be therapeutic also because it involves the addict in a socially acceptable routine of daily activity that is productive and far removed from his former destructive, drug-centered lifestyle. Such comprehensive rehabilitation programs help the addict to rebuild his life and develop a more positive self-image. Many addicts claim that heroin is a "slow way to suicide." Thus the ideal cure for heroin addiction is creating in the addict the desire to live.

Opinions

> ". . . An addict is the most pathetic creature on earth. He knows that every time he sticks a needle in his arm, he's gambling with death and yet he's got to have it. . . . There's always the danger that some peddler will sell him a poisoned batch --- some garbage."
>
> --Art Peters (1967)

Billie Holiday, a renowned blues singer whose career dated from the 1930's and spanned over two decades, stated in her autobiography:

> All dope can do for you is kill you -- and kill you the long slow hard way. And it can kill the people you love right along with you. And that's the truth, the whole truth, and nothing but.
>
> --Billie Holiday
> from her autobiography,
> Lady Sings the Blues

> The surest way to identify a heroin user in a slum neighborhood is to observe the way people walk. The heroin user walks with a fast, purposeful stride, as if he is late for an important appointment - indeed he is. He is hustling (robbing or stealing), trying to sell stolen goods, avoiding the police, looking for a heroin dealer with a good bag (the street retail unit of heroin), coming back from copping (buying heroin), looking for a safe place to take the drug, or looking for someone who beat (cheated) him - among other things. He is in short, taking care of business . . . For them, if not for their middle and upper-class counterparts (a small minority of opiate addicts), the quest for heroin is the quest for a meaningful life, not an escape from life. And the meaning does not lie, primarily, in the effects of the drug on their minds and bodies; it lies in the gratification of accomplishing a series of challenging, exciting tasks, every day of the week.
>
> --Edward Preble and
> John Casey, Jr. (1969)

> We think it high time . . . to call a policy of forcing the addict from degradation to degradation, and all in the name of concern for his welfare, just what it is - vicious, sanctimonious, and hypocritical . . . Every addict is entitled to assessment as an individual and to be offered the best available treatment in the light of his condition, his situation, and his needs. No legislator, no judge, no district attorney, no director of a narcotics bureau, no police inspector, and no narcotics agent is qualified to make such an assessment . . . In extreme cases, it may be that the best that can be offered an addict is to help him to stay chronically narcotized; if so, such a case is as entitled to such treatment as is a terminal cancer patient . . . If the best that our society has to offer . . . is narcosis, what moral right do we have to withhold it from

them? Dare we, in our arrogance, take the position that it is proper to keep these people from finding relief merely because we find their method of finding relief offensive to us?

--Isidore Chein et al. (1964)

The decision to use methadone on a large scale supports, and indeed reinforces, a drug-oriented approach to the solution of social and personal problems. Such a decision, apparently taken with only the heroin addict as the target, may have untoward consequences for large groups of persons not yet inducted into the use and misuse of psychoactive drugs to regulate the disturbances of social life. For example, what effect does it have on the young who are rejecting the drug route or on the former addicts who wish to live a drug-free life to see society commit itself to dispensing a drug as potent as methadone.

--Henry L. Lennard et al. (1972)

Drug abuse patterns are changing rapidly. Younger people are becoming addicted and seeking medical aid. The established medical community is reluctant to treat young addicts and they are repeatedly turned away, or they decline help from traditional sources of medical treatment. Narcotic detoxification alone is insufficient for rehabilitation of these young addicts. Unless present legal restraints on treating minors are significantly modified or removed, the young addict will continue to turn away from traditional sources of help.

--Barry S. Ramer et al. (1972)

Pertinent Drug Abuse Legislation

1906 — Pure Food and Drug Act: Required patent medicine labels to list all "dangerous substances" contained.

1912 — Hague Conference: Agreement reached that production and trade of opiates and opium be limited to amounts necessary for medical and scientific use only.

1914 — Harrison Narcotic Tax Act (a tax law): Persons authorized to handle or manufacture drugs required to register, pay a fee and keep records of all narcotics in their possession.

1919-24 — Establishment of Public Outpatient Narcotic Clinics: Opened in hopes of rehabilitating the addict and preventing his involvement with criminal drug distributors. In general badly managed, by 1924 all were forced to close by a moralizing and crusading press and the Federal Bureau of Narcotics. Illicit narcotics became the addict's only supply.

1920 — Volstead Act: Non-medical usage of alcoholic beverages prohibited.

1922 — Behrman Case: Prevented M.D.'s from legally supplying drugs to addicts for self administration. Implied that addicts must be isolated and hospitalized. Led eventually to the Public Health Service hospitals in Lexington, Kentucky (1935) and Fort Worth, Texas (1938).

1922 — Jones-Miller Act (Narcotics Drug Import and Export Act): Established firm penalties for violation of the Harrison Act.

1924 — Prohibition of manufacture of heroin in the United States.

1925 — Supreme Court ruled that a physician may administer narcotics to allay withdrawal symptoms, if done in good faith. The Federal Bureau of Narcotics ignored this ruling, punishing physicians who give narcotics to addicts.

1933 — Repeal of Prohibition of alcohol.

1937 — Marihuana Tax Act: Marihuana was brought under stern controls similar to those regulating the use of opiates.

1951 Boggs Act: Graduates sentences with mandatory minimum sentences for all narcotic drug offenses. Subsequent to the passage of the Boggs Act many State legislatures enacted "little Boggs Acts."

1956 Narcotic Drug Control Act: Even more punitive than the Boggs Act, it did, however, differentiate among drug possession, drug sale and drug sale to minors. Medical use of heroin prohibited.

1956 All existing heroin supplies in the United States were surrendered to the government.

1963 Supreme Court (Robinson vs. California): Declared that addiction is a disease, not a crime. Legally an addict cannot be arrested for being "high" (internal possession) but he can be arrested for the external possession and sale of drugs.

1966 Narcotic Addict Rehabilitation Act: Views narcotic addictio as being symptomatic of a treatable disease and not of a criminal condition.

1966 Drug Abuse Control Amendments: Laws became effective whereby sedatives, stimulants and tranquilizers came under tighter controls. Hallucinogens were specifically added to the laws in 1966. Enforcement became the responsibility of the Bureau of Drug Abuse Control in the Food and Drug Administration.

1968 Bureau of Narcotics and Dangerous Drugs (Department of Justice): Was given responsibility on a federal level for the entire drug problem. The Bureau of Narcotics was removed from the Department of the Treasury and the Bureau of Drug Abuse Control from the Food and Drug Administration and the two bureaus combined.

1969 Operation Intercept: An attempt to block import of marihuana at the Mexican border. It coincided with increased use of "harder" drugs throughout the country.

1969-71 Tightening of controls at a federal level and urging of foreign governments to apply firmer restrictions in regard to manufacture and exportation of drugs.

1970 Comprehensive Drug Abuse Prevention and Control Act of 1970: Replaced previous acts for control of narcotics, marihuana, sedatives and stimulants and placed their control under the Department of Justice. Drugs are classified into five schedules according to their potential for abuse and therapeutic usefulness. First time illegitimate possession of any drug in the five schedules is considered to be a misdemeanor and penalties are reduced. Provisions are made for rehabilitation, education and research. House search ("no-knock" law) legalized.

1972 Drug Abuse Office and Treatment Act: Brought about by the increasing drug use by United States troops in Vietnam and increased use in the United States; this law established the Special Action Office for Drug Abuse Prevention to be the coordinator of the nine Federal agencies involved in drug abuse activities. With an emphasis on treatment and rehabilitation programs, SAODAP develops Federal strategies for all drug abuse efforts outside of drug traffic prevention. Also detailed in the legislation was the establishment of the National Institute on Drug Abuse, which took place in April 1974. This organization will continue the programs established by SAODAP.

References

Adriani, John. The Chemistry and Physics of Anesthesia. Springfield, Ill.: Charles C Thomas, 1962. 849 pp.

Anslinger, Harry J., and Tompkins, William F. The Traffic in Narcotics. New York: Funk & Wagnalls, 1953. 354 pp.

Blair, T.S. The doctor, the law, and the addict. American Medicine, 27: 581-588, 1921.

Buell, R.L. The opium conferences. Foreign Affairs, 3: 567-583, 1925.

Burroughs, William. Junkie. New York: Ace Books, 1953. 62 pp.

Chein, I.; Gerard, D.L.; Lee, R.S.; and Rosenfeld, E. The Road to H: Narcotics, Delinquency, and Social Policy. New York: Basic Books, 1964. 482 pp.

Committee of Concerned Asian Scholars. The Opium Trail. Boston: New England Free Press, 1972.

Committee on the Narcotic Drug Situation in the United States. Report to the AMA House of Delegates. Journal of the American Medical Association, 74(19): 1324-1325, 1920.

Day, Horace. (Attributed to). The Opium Habit, with Suggestions as to the Remedy. New York: Harper & Bros., 1868.

Dole, Vincent P., and Nyswander, Marie. A medical treatment for diacetylmorphine addiction. Journal of the American Medical Association, 193(8): 646-650, 1965.

Editorial. Journal of the American Medical Association, 64(1): 834-845, 1915.

Editorial. Journal of the American Medical Association, 64(1): 911-912, 1915.

Einstein, Stanley. The Use and Misuse of Drugs. Belmont, Calif.: Wadsworth Publishing Co., 1970.

Fields, Albert, and Tararin, Petter A. Opium in China. British Journal of the Addictions, 64(3/4): 371-382, 1970.

Fink, Max. Heroin maintenance. (Letter to the Editor). Journal of the American Medical Association, 221(6): 602, August 7, 1972.

Gay, G.R.; Matzger, A.D.; Bathurst, W.; and Smith, D.E. Short-term heroin detoxification on an outpatient basis. International Journal of the Addictions, 6(2): 241-264, 1971.

Gay, George R., and Way, E. Leong. Some pharmacological perspectives on the opiate narcotics with special consideration of heroin. Journal of Psychedelic Drugs, 4(1): 31-39, Fall 1971.

Goldsmith, Margaret. The Trail of Opium: The Eleventh Plague. London: Robert Hall, Ltd., 1939. 286 pp.

Grosz, A.J. Successful treatment of a heroin addict with propranolol: implications for opiate addiction treatment and research. Journal of the Indiana State Medical Association, 65(6): 505-509, June 1972.

Halpern, S. The Army and heroin addiction. Listen, a Journal of Better Living, August 1972.

Hess, A.C. Deviance theory and the history of opiates. International Journal of the Addictions, 7(4): 585-598, December 1971.

Holiday, Billie. An autobiography. Lady Sings the Blues. New York: Lancer Books, 1972.

Irwin, Samuel. Drugs of abuse: an introduction to their actions and potential hazards. Journal of Psychedelic Drugs, 3(2): 5-15, Spring 1971.

Jaffe, Jerome H. Cyclazocine in the treatment of narcotic addiction. In: Masserman, J., ed. Current Psychiatric Therapies. New York: Grune & Stratton, 1967. pp. 147-156.

Jaffe, Jerome H. Drug addiction and drug abuse. In: Goodman, Louis S., and Gilman, Alfred, eds. The Pharmacological Basis of Therapeutics. 4th ed. New York: MacMillan, 1970. pp. 276-313.

Jaffe, Jerome H. Narcotic analgesics. In: Goodman, Louis S., and Gilman, Alfred, eds. The Pharmacological Basis of Therapeutics. 4th ed. New York: MacMillan, 1970. pp. 237-275.

Jaffe, Jerome H.; Zaks, M.S.; and Washington, E.N. Experience with the use of methadone in a multi-modality program for the treatment of narcotic users. International Journal of the Addictions, 4(3): 481-490, 1969.

Keys, Thomas Edward. The History of Surgical Anesthesia. New York: Dover Publishers, 1963. 193 pp.

Kramer, John C. Controlling narcotics in America. (Two parts) Drug Forum, 1(1): 51-69, January 1972 and 1(2): 153-167, February 1972.

Lee, John A., and Atkinson, R.S. A Synopsis of Anaesthesia. 5th ed. Baltimore: Williams & Wilkins Co., 1964. pp. 66-76.

Lennard, Henry L.; Epstein, Leon J.; and Rosenthal, Mitchell S. The methadone illusion. Science, 176(2): 881-884, May 26, 1972.

Lindesmith, Alfred Ray. The Addict and the Law. Bloomington, Ind.: University Press, 1965. 337 pp.

Livingston, Robert B., ed. Narcotic Drug Addiction Problems. Washington, D.C.: U.S. Public Health Service, 1963. 212 pp.

Louria, Donald B., and Wolfson, Edward A. Medical complications of drug abuse. Drug Therapy, August 1972.

Lowes, P.D. The Genesis of International Narcotics Control. Geneva: Librairie Droz, 1966.

LSD therapy in heroin addiction, medical scene. Modern Medicine, 40(12): 39-41, June 12, 1972.

Martin, W.R.; Gorodetsky, C.W.; and McClane, T.K. An experimental study in the treatment of narcotic addicts with cyclazocine. Clinical Pharmacology and Therapeutics, 7: 455-465, 1966.

Meyers, Frederick H.; Jawetz, Ernest; and Goldfein, Alan. Review of Medical Pharmacology. Los Altos, Calif.: Lange Medical Publications, 1968. 692 pp.

Mo, Benjamin P., and Way, E. Leong. An assessment of inhalation as a mode of administration of heroin by addicts. Journal of Pharmacology and Experimental Therapeutics, 154(1): 142-151, 1966.

The new public enemy No. 1. Time, June 28, 1971.

Owen, D.W. British Opium Policy in China and India. New Haven: Yale University Press, 1934.

Pereira, Jonathon. The Elements of Materia Medica and Therapeutics. 2nd American ed., Vol. 2. Philadelphia: Lea and Blanchard, 1846. 1093 pp.

Peters, Art. Comeback of a child star - singer Frankie Lymon returns to footlights after battle with drugs. Ebony. January 1967.

Preble, Edward, and Casey, John H. Taking care of business: the heroin user's life on the street. International Journal of the Addictions, 4: 1-24, 1969.

Prentice, Alfred C. The problem of the narcotic drug addict. Journal of the American Medical Association, 76(2): 1551-1554, 1921.

Ramer, Barry S., Smith, David E.; and Gay, George R. Adolescent heroin abuse in San Francisco. International Journal of the Addictions, 7(3): 461-465, 1972.

Ratner, Richard A. Drugs and despair in Vietnam. University of Chicago Magazine, 15-23, May/June 1972.

Review of "apologia"; or confessions of an English opium eater: being an extract from the life of a scholar. Medico-Chirurgical Review, 2: 881-901, 1822.

Senay, Edward C., and Renault, Pierre F. Treatment methods for heroin addicts: a review. Journal of Psychedelic Drugs, 3(2): 47-54, Spring 1971.

Sheppard, Charles W.; Gay, George R.; and Smith, David E. The changing patterns of heroin addiction in the Haight-Ashbury subculture. Journal of Psychedelic Drugs, 3(2): 22-30, Spring 1971.

Sheppard, Charles W.; Gay, George R.; and Smith, David E. Emergency treatment of acute depressant drug overdose. Missouri Medicine, 69(1): 102-111, February 1972.

Smith, David E., and Gay, George R., eds. It's So Good, Don't Even Try It Once: Heroin in Perspective. Englewood Cliffs, N.J.: Prentice-Hall, 1972. 208 pp.

Smith, Roger C. U.S. marihuana legislation and the creation of a social problem. In: Smith, David E., ed. The New Social Drug. Englewood Cliffs, N.J.: Prentice-Hall, 1968. pp. 105-117.

Sonndecker, Glenn. Emergence and concept of the addiction problem. Symposium on the History of Narcotics Addiction. Bethesda, Md.: U.S. Public Health Service, 1958. pp. 14-22.

Terry, Charles E., and Pellens, Mildred. The Opium Problem. New York: Bureau of Social Hygiene, Inc., 1928. 1042 pp.

Way, E. Leong. Contemporary classification, pharmacology, and abuse potential of psychotropic substances. In: Wittenborn, John Richard, et al., eds. Drugs and Youth. Springfield, Ill.: Charles C Thomas, 1969. pp. 27-36.

Wellisch, David K.; Gay, George R.; and McEntee, Roseann. The easy rider syndrome: a pattern of hetero and homosexual relationships in a heroin population. Journal of Family Practice, 9: 425-430, 1970.

Wesson, Donald R.; Gay, George R.; and Smith, David E. Managing narcotic and sedative withdrawal. Hospital Physician, 1-4, January 1972.

Wood, Horatio C. A Treatise on Therapeutics and Pharmacology or Materia Medica. 2 vols. Philadelphia: Lippincott, 1884.

Wood, H.C., Jr. Dope: the story of the use and abuse of opium. American Journal of Pharmacy, 103: 16-27, January 1931.

Young, George. A Treatise on Opium. London: A. Miller, 1753. 182 pp.

Zinberg, Norman E. Heroin use in Vietnam and the United States. Archives of General Psychiatry, 26(5): 486-488, May 1972.

The National Clearinghouse for Drug Abuse Information, operated by the National Institute on Drug Abuse on behalf of the Special Action Office for Drug Abuse Prevention and the Federal agencies engaged in drug abuse education programs, is the focal point for Federal information on drug abuse. The Clearinghouse distributes publications and refers specialized and technical inquiries to Federal, State, local, and private information resources. Inquiries should be directed to the National Clearinghouse for Drug Abuse Information, P.O. Box 1908, Rockville, Maryland 20850.

Audience: Adult/Technical

The National Clearinghouse for Drug Abuse Information should be contacted for advice and assistance in the reproduction of this report if any modifications in content or layout are planned.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
ALCOHOL, DRUG ABUSE, AND
MENTAL HEALTH ADMINISTRATION
5600 FISHERS LANE
ROCKVILLE, MARYLAND 20852

OFFICIAL BUSINESS
Penalty for private use, $300

POSTAGE AND FEES PAID
U.S. DEPARTMENT OF H.E.W.
HEW 389

HSM-76 Assoc Director
Eric Info Analysis Ctr for SMEE
The Ohio State Univ
400 Lincoln Tower
Columbus OH 43210

NOTICE OF MAILING CHANGE

☐ Check here if you wish to discontinue receiving this type of publication.

☐ Check here if your address has changed and you wish to continue receiving this type of publication. (Be sure to furnish your complete address including zip code.)

Tear off cover with address label still affixed and send to:

Alcohol, Drug Abuse, and Mental Health Administration
Printing and Publications Management Section
5600 Fishers Lane (Rm. 6-105)
Rockville, Maryland 20852

DHEW Publication No. (ADM) 75-198
Printed 1975

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
5600 Fishers Lane
Rockville, Maryland 20852